MISSOURI COMMISSION ON PATIENT SAFETY
MEETING MINUTES
May 19, 2004
10:00 a.m. – 4:00 p.m.
Capitol Plaza Hotel
Jefferson City, Missouri

OFFICIAL

Commissioners in attendance: Gregg Laiben, Deborah Jantsch, Susan Kendig, Nancy Kimmel, Scott Lakin, Alan Morris, Kathryn Nelson, Bea Roam, William Schoenhard, Stephen Smith, James Utley, Lori Scheidt.

I. CALL TO ORDER

Dr. Gregg Laiben, Chairperson
The meeting was called to order at 10:30 AM. Silent roll call was taken.

Review of Draft Minutes from the previous meeting

There were no corrections noted for the previous draft meeting minutes. Dr. Morris moved to accept. Dr. Utley seconded. The minutes were approved on a voice vote and there were no objections.

Housekeeping items:

- All Commissioners should have received the most recent draft recommendations, the revised recommendations from the professional Boards and the draft Glossary via email. Copies are available today.
- A corrected signature page for the letter to Governor Holden is here today. There are 6 copies. Any person comfortable with signing the letter today is invited to do so, but MDI requests that all 6 copies be signed, so that back-up copies are available in the event something goes wrong.
- Randy McConnell has not yet gotten confirmation from the Governor's office on the date for presenting the report. He requested either June 30th or July 7th. It will definitely be one of those two dates. **All Commissioners are asked to keep both dates clear until further notice.**

- For those unable or unwilling to sign the letter today, they will have an opportunity to sign on the date the presentation is made. Any Commissioner that doesn't sign today and won't be able to sign on the date of the presentation is asked to **let Linda know as soon as possible**. The signature pages will be Fed-Ex'd back and forth to those that need to do it this way, but there will be a very limited amount of time to accomplish this.

II. WORKING MEETING

Dr. Laiben noted that all the draft recommendations needed to be discussed and agreed to today. Any revisions need to be thoroughly discussed to ensure that all Commissioners and staff have the same understanding for each recommendation. Commissioners were asked to focus on the major concepts, ascertain agreement or disagreement, and leave detailed word-smithing to staff.

Recommendation #1: Missouri should establish a "Patient Safety Center" with statewide responsibility for specific tasks related to patient safety. The "Center" will be a public-private partnership and represent a broad spectrum of healthcare issues. (Sub-points a through h noted below if individually discussed)

Kathryn Nelson reported that she had shared this draft with professional associates. She was disappointed in their response on several counts. First, their understanding of the draft was that a new state government agency was to be established. This seemed to be the result of several sub-points on the subject of reporting. The Commission needs to clearly articulate that this will NOT be a state/regulatory body. This could be placed as one of the sub-bullets. Second, people felt Missouri was trying to establish something new for which no model existed. However, many states **have** already established safety "Centers" of their own. The Veteran's Administration also has a "Center". The perception that a "Center" is a new, unique idea needs to be countered somehow, perhaps in the Executive Summary.

Dr. Jantsch indicated she had gotten a similar reception when she shared the draft with other doctors. They found it unreadable. They didn't pick up on how important the changes to the peer-review protection law were going to be. Since the #1 recommendation is the "Center", readers fixate on that, and perceive it as a new bureaucracy. If a better way could be found to communicate the process the Commission has been through to reach these recommendations, that might give readers a better understanding of why the Commission is recommending each item.

Dr. Laiben felt the reaction from his peers and associates had been the same as Kathryn Nelson and Dr. Jantsch described. The recommendations as currently drafted are creating the impression that the "Center's" sole function will be to collect mandated reports. This is not the direction the Commission wants to go.

Randy McConnell reiterated that the draft recommendations are NOT the executive summary. The executive summary will explain in more detail, and the meat of the report will be in the 40-page document that follows. The total concept cannot be explained in a few pages.

Kathryn Nelson posed the question, should reporting be a sub-point or should it stand alone as a main recommendation? What does the Data and Reporting Subcommittee think?

Dr. Smith responded that, since the Subcommittee itself experienced internal disagreement on this point, it would likely be best to keep reporting recommendations as sub-points under some other main recommendation.

Kathryn Nelson noted that most states pursuing patient safety on a statewide basis are in fact passing laws requiring safety data reporting. However, they all seem to be missing the importance of focusing on lessons learned, solutions to specific problems and tools that any provider could adopt to address similar safety challenges. Missouri will stand apart from the crowd if we focus on sharing lessons, not collecting data. This point should not be lost.

Kathryn Nelson further noted that Texas is helping small institutions and health care settings do root cause analysis when the setting lacks internal resources for doing their own. Missouri's "Center" should be able to serve in this capacity too. That would be a valuable resource for providers.

Discussion of mandatory versus voluntary reporting of safety data followed. Some Commissioners reiterated that mandatory reporting (according to testimony) has not been very successful. Data collection involves setting up a way to collect and disseminate information. There is not enough time for the Commission to fully investigate this. In addition, reporting of sentinel events is not the ideal tool for learning from mistakes. The best learning tool is 'near miss' data. Near-miss data should be collected by each health care setting and analyzed internally. It must be collected internally before it can be reported to a "Center". It may not be necessary to report near-miss data to the Center.

Dr. Utley called attention to the name of the "Center", and suggested it be changed to "Patient Safety **RESOURCE** Center", to emphasize the supportive roll the Commission envisions, and dilute the perception of a new regulatory agency. Dr. Laiben countered that he liked "Support Center" instead of "Resource Center". Dr. Utley indicated that was fine with him too. **The Commission agreed on "Patient Safety Support Center".**

William Schoenhard suggested that #1e should read differently. (The draft states "The "Patient Safety Center" should work with the federal government, regulatory agencies, JCAHO (Joint Commission on the Accreditation of Healthcare Organizations), and any other organization widely involved with patient safety reporting to implement a standardized report format for use by all Missouri healthcare organizations. Upon adoption of the standardized report form, require that all Missouri healthcare organizations use the standard format to report to the "Patient Safety Center".) He recited the draft he jotted down, and also gave his notes to MDI staff. Dr. Laiben noted that Mr. Schoenhard's language addresses the issues raised by Dr. Utley and Nancy Kimmel. **The Commission agreed to this revision.**

Dr. Utley noted that, if solutions are shared with the "Center" and distributed statewide, there needs to be a way to track whether or not they worked. Some "solutions" won't work. Dr. Smith agreed and noted that this supports the notion of near-miss reporting, which would allow the "Center" to see if near-misses went down. Dr. Utley read a draft of his idea aloud, and **the Commission agreed to his idea.** Dr. Utley provided a copy of his suggestion to MDI staff.

At this point, a revised version of Recommendation #1 and sub-points was distributed.

Kathryn Nelson re-emphasized that the "Center" needs to offer technical assistance. It should be a resource for tracking national activities. The recommendation should emphasize the concept of the "Center" as a clearing house.

Kathryn Nelson posed the question formally, should the Commission recommend near-miss reporting, or recommend further study of this issue by the "Center"?

Dr. Laiben stated that he preferred the latter. The former would require a lot of definitions, and runs the risk of being misunderstood. Other states are starting to see the problems with data collection. Several Commissioners agreed. However, Kathryn Nelson noted that internal reporting was still important. Dr. Utley suggested that any recommendation on reporting should be further down the list of sub-points.

Scott Lakin noted that no external reporting will happen unless a law is written and passed requiring it. If there is a recommendation on external reporting, it should simply state that the "Center" will advise the legislature on what's needed. The "Center" should not be put in a straight jacket. It should be able to deal with the reality that different providers are at different stages of development with regard to establishing a patient safety culture and collecting safety information internally, let alone reporting data externally.

The Commission generally agreed that **the order of recommendations and sub-points** will convey a strong message, and **should emphasize education and legal protection ahead of external data reporting**. Nancy Kimmel felt protection has to precede education, but Dr. Laiben warned that putting legal protection first could be perceived by the public as self-serving on the part of physician Commissioners.

Dr. Laiben raised the issue of funding. The Commission should expect that no state money is available for this, and providers cannot support it entirely on their own. Should the report attempt to address the funding problem?

Dr. Utley suggested that the report should acknowledge the problem with funding the "Center", and note that a balance of public and private funds is preferred. Scott Lakin countered that public money implies a regulatory function. He also wasn't comfortable with the possible legal ramifications of using public money to fund the "Center". However, Kathryn Nelson pointed out that other states have used public funds. Dr. Utley asked if any Commissioner envisioned purely private funding. No Commissioner indicated this was their perception.

William Schoenhard suggested the report should name a handful of organizations willing and able to contribute seed money to start the "Center", and to provide initial leadership. Susan Kendig noted that the report should avoid the perception that people must buy their way into the "Center". No group or organization should be seen has overly controlling.

Dr. Jantsch noted that the federal bill (HB 663) on patient safety addresses funding. Linda Bohrer noted that the background material for the report also hits funding.

There were no further comments on this recommendation. Dr. Laiben asked to move on.

EXECUTIVE SUMMARY:

William Schoenhard asked to look at the Executive Summary first. He felt it was important for the **Executive Summary to show that testimony produced specific findings, and that each specific finding was then tied to a specific recommendation.** Statements of findings should be short and simple. **The Commission agreed this should be the format for the Executive Summary** because it will set the stage for the recommendations to follow. If some readers get no farther than the summary, at least specific problems will be stated.

There were no further comments on this recommendation. Dr. Laiben asked to move on.

Recommendation #2: Improve communication among, and education of, healthcare professionals and consumers in order to share best practices, make informed decisions about health care and learn from others' mistakes. (Sub-points a through e noted below if individually discussed)

Susan Kendig asked if the wording could be revised to put education ahead of communication. Also, given what has been discussed about the importance of order, and the importance of legal protection, **should recommendation #3 come before recommendation #2? Kathryn Nelson felt it should.**

Nancy Kimmel suggested that a sub-point should be added stating that educational initiatives will be accomplished by working with and through the existing bodies responsible for setting educational requirements. She drafted some language and provided that to MDI staff. **The Commission agreed to Ms. Kimmel's suggestion.**

Linda Bohrer asked that the Commissioners consider moving #2 b (Support the patient's central role in the healthcare team through education and resource materials. Identify available patient education materials and assist in making them available to all Missourians. Encourage the development of useful and innovative patient education materials.) to recommendation #7. **Should patient education be pulled out of #2 and stand on its own? The Commission generally agreed that this was desirable.**

Dr. Utley asked that "learn from others' mistakes" be removed, as it emphasized individual culpability rather than system breakdowns. **Kathryn Nelson suggested using "learn from adverse events" instead.**

Dr. Jantsch suggested that some emphasis should be given to educating the consumers about the difference between innocent error and actual malpractice.

There were no further comments on this recommendation. Dr. Laiben asked to move on.

Recommendation #3: Broaden protection for peer review activities and establish protection for quality assurance activities in order to encourage healthcare professionals to volunteer information and to participate in peer review/quality improvement activities which will lead to increased patient safety. (Sub-points a through d noted below if individually discussed)

Dr. Utley asked to change "volunteer" to "report or "voluntarily report".

Dr. Jantsch felt the justification was missing from this section. Legal protection is a foundational concept. Lack of legal protection for patient safety investigations keeps some providers from doing anything. Kathryn Nelson concurred, but felt the

Executive Summary would emphasize why legal protection is important. Dr. Smith pointed out that the federal HB 663 contains good language for describing this problem.

Kathryn Nelson felt the recommendation was unclear as to what was protected. It should be more clearly stated that data is protected.

Some Commissioners were not clear where the wording of this recommendation was coming from. Linda Bohrer clarified that the wording was specific language given to her by the attorneys on the Data Protection and Reporting Subcommittee.

Scott Lakin warned that the words "broaden protection" would be a red flag for consumer advocates. The intent of ensuring the free flow of information without fear of litigation should be stated in a way that emphasizes the consumer benefit.

Dr. Utley felt that the recommendation on disclosure to patients should be emphasized as the "compromise" or "trade" for better legal protection of safety data and activities. Also, the recommendation is not clear on how patient safety emphasizes system-wide analysis. Peer review is widely perceived as pertaining to review of one practitioner in his or her treatment of one patient. This perception is what needs to be broadened.

Nancy Kimmel said that when she shared the draft recommendations with the legal counsel for her hospital, they raised the same concern as Dr. Utley. She read some suggested language for extending peer review protections to any committee that reviews systems. She gave the draft language to MDI staff. Dr. Utley indicated that he preferred this alternative language. **The Commission agreed to use this language.**

Additional items that Nancy Kimmel's legal colleagues raised were: disclosure to the patient shouldn't be construed as a waiver of legal protection; the "Center" should not become the new standard of care by which all providers can be judged. If the "Center" disseminates a recommended best practice, a provider should not necessarily be liable just because they don't use that practice.

Kathryn Nelson noted that other states have left their peer review laws alone, and have opted to establish new laws devoted to protecting patient safety activities. Dr. Utley said that this was discussed in the Subcommittee, and they felt it was easier from a political perspective to change existing laws than to get new ones passed. Scott Lakin noted that, on the other hand, opening an existing section of law means anything about that section can get changed.

Nancy Kimmel asked if "quality assurance" could be replaced with "patient safety and quality improvement" to avoid pre-conceived notions of what "quality assurance" means.

Dr. Smith noted that the Federal HB 663 contains language that protects "reporters", whether reporting internally or externally. This has the effect of protecting whistleblowers without saying "whistleblowers". Protection is available without creating disincentives to report. Nancy Kimmel noted that her legal colleagues had questioned the same issue.

Kathryn Nelson asked if "without fear of reprisal" was sufficient. Nancy Kimmel felt that "fear of whom" and "reprisal" would have to be defined if used.

Dr. Laiben asked if the Commission agreed to use the language from the Federal bill as a recommendation on this issue. Linda Bohrer asked where it should go. Dr. Utley suggested it should go with the recommendations for all organizations, #6. Dr. Smith disagreed. He felt that #3 dealt with eliminating disincentives to report, and that this issue is a big disincentive to report.

Dr. Laiben adjourned the Commission from noon to 1 PM for lunch but noted the discussion should resume afterwards.

Dr. Smith resumed by pointing out that the Federal language was not to be a suggestion for legislation in Missouri, but to be used to formulate a statement about the Commission's philosophy.

The Commission agreed to keep this item as part of recommendation #3.

Dr. Laiben asked if Linda Bohrer was clear on how #3 should be redrafted to emphasize the free flow of information. Linda responded that she was, and that Dr. Jantsch had supplied some draft language.

There were no further comments on this item. Dr. Laiben asked to move on.

Recommendation #4: Standardize information to be collected on a statewide basis related to patient safety errors. Conduct additional studies to determine the extent of information that needs to be reported in order to understand the nature and root cause of errors. (Sub-points a and b noted below if individually discussed).

It was noted that mandatory reporting to patients is under recommendation #6. Questions were asked about how this would be enforced, and who would enforce it.

It was noted that "disclosure" is a more appropriate term than "reporting", for number 4a ("Require mandatory reporting of adverse events to patients or, in the case of a minor or a patient who is incapacitated, the patient's parent or guardian or other family member as appropriate, to allow for their participation in informed ongoing healthcare decisions.") "Reporting" connotes information submitted by providers to the "Center" or a regulatory agency, which is not the subject of this sub-point.

It was noted that the term health care "provider" meant "hospital" to many people. Linda Bohrer said the definitions will take care of this perception.

William Schoenhard noted that, considering the morning discussion, #4 should be eliminated. It was noted that both sub-points are addressed under other recommendations. **The Commission agreed to delete #4**.

There were no further comments on this item. Dr. Laiben asked to move on.

Recommendation #6: All Missouri healthcare organizations should adopt minimum standards for improving the safety of their patients. (This is the redrafted version. Sub-points noted below where individually discussed.)

Dr. Utley asked again if #6f ("Develop a program for disclosing information and providing counseling to patients and their families, who have been affected by an adverse event.") shouldn't be connected to #3 somehow, to emphasize the trade off between expanded legal protection and sharing information with patients.

Dr. Laiben suggested moving #6 up to the #1 position, and renumbering the recommendations. This would give prominence to disclosure and also reduce the perception of the "Center" as a regulatory agency. This could serve as a preamble to the rest of the recommendations. Dr. Utley asked that #6 f be moved too, to #6 a. **The Commissioners agreed with this.**

William Schoenhard felt moving #6 to the #1 position might be perceived as punitive, since #6 is a list of things health care providers should have or do. Dr. Laiben asked if using a word or phrase besides "minimum standard" would be preferable. Kathryn Nelson added that "standard" evokes JCAHO.

Randy McConnell pointed out that the last sub-points ("Missouri should consider making adoption of these minimum standards a condition for participating in the Medicaid program, especially for larger facilities and group practices" and "The Patient Safety Center should work with insurers and the new Missouri Medical Malpractice Joint Underwriting Association board of directors to provide medical liability discounts for healthcare professionals and organizations that follow the state's minimum standards") don't work very well if "standard" is not used. One

option would be to not use the last two sub-points. Commissioners were mixed on how strongly they felt about these two sub-points. Kathryn Nelson did not want to lose the importance of the state's role as a purchaser and provider of healthcare services. **After discussion it was decided that the last two sub-points would be revised and relocated.**

Kathryn Nelson felt the first bullet point was not correct, in that it should not be the Patient Safety Officer's job to create a patient safety culture or to single-handedly correct system failures. **These last two topics should be separate sub-points on their own. The Commission agreed with this.**

The definition of "health care organization" from the draft glossary was read. Several Commissioners pointed out that the definition does not fit very well with the sub-points under #6. The sub-points assume a health care organization is giving direct patient care, but the definition incorporates things like professional societies and HMOs, which do not give direct patient care. William Schoenhard suggested targeting the definition at those types of providers where the risks to patient safety are known to be the highest. Linda Bohrer asked Commissioners to consider how the term is used throughout the report. It might be preferable to use a different term altogether for #6. A new term and definition should leave out entities not giving patient care, but should keep providers of indirect care, such as durable medical equipment providers or pharmacies. Dr. Laiben asked Linda Bohrer to work with the Hospital Association to determine where the existing definition was appropriate, and where a different term and definition should be used, if at all.

Nancy Kimmel asked if, under the disclosure sub-point ("All healthcare organizations should create programs for disclosing errors and providing counseling to patients and their families who have been affected by adverse events"), counseling for the staff involved with the adverse event could be added. Dr. Laiben pointed out that certain organizations would not and should not be involved with counseling anybody. Several other Commissioners agreed, and felt the counseling piece should be removed. **The Commission agreed the disclosure piece should stand-alone.**

Nancy Kimmel felt the recommendations should not imply that a patient safety culture is one in which there is no accountability. Linda Bohrer noted that there had been a draft definition for "patient safety culture" which made this clear. It was dropped, but it can be put back. **The Commission agreed to have a definition that makes this clear.** Kathryn Nelson suggested using national sources, such as the Institute of Medicine reports for this definition.

Dr. Laiben summarized: **Recommendation #6 will be moved up and made recommendation #1. Disclosure will be the first sub-point, and will not mention counseling. Counseling will stand-alone. The first sub-point will be split into 3 separate sub-points. The last two sub-points will be moved out of #6 completely and placed elsewhere in the report. The sub-point on whistleblower protection will be revised and will be repeated in the legal protection recommendation.**

There were no further comments on this item. Dr. Laiben pointed out that Recommendation #5 was skipped and asked to go to that one next.

Recommendation #5: The legislators, elected officials, and associations representing healthcare professionals and healthcare organizations need to work together with the regulatory agencies to enhance the authority of the regulators so they can effectively keep watch over (monitor) activities of those entities that can have an adverse impact on patient safety and cause patient harm.

Linda Bohrer explained that two different versions of a single sub-point were presented in the draft document, and Commissioners should pick which one, if either, they want to go with.

There was disagreement on including the Boards' recommendations. Some Commissioners did not feel sufficiently prepared to formally recommend statutory changes related to professional regulation. Other Commissioners noted that the Boards have been an integral part of this Commission from the beginning, and the Commission risks losing credibility if known statutory problems are not addressed.

Lori Scheidt argued that certain problems with the current statutory language should be obvious enough to agree on changing. She emphasized that the Boards are not interested in near-miss data reporting. However, all the Boards struggle with the problem of tracking truly problematic practitioners, and intervening in a timely fashion. Part of the problem lies in the limited number of providers which must report to the Boards, and the limited scope of practitioner types which providers must make reports regarding.

Q: Is final disciplinary action related nurses and respiratory therapists subject to requirements to report to the Boards?
A: (Lori Scheidt) Only if their place of employment is a hospital or ambulatory surgical center. Other healthcare settings, such as nursing homes, are left out of the law. In addition, if a nursing home asks the Boards about final disciplinary action taken against a practitioner, the Boards are not free to share that information. This prevents nursing homes from being able to use the same information that hospitals and ambulatory surgical centers might use to prevent employment of a problematic practitioner.

The Commission adjourned for a short break. During that time, several Commissioners got together and worked out an alternative draft recommendation. MDI staff distributed copies of the laws that the Board of Nursing specifically pointed to in their report as being problematic, sections 383.130 and 383.133, RSMo. The draft alternative was projected so everyone could see it.

Dr. Laiben asked what the penalty is for an infraction of section 383.133, RSMo. Lori Scheidt confirmed that there is no penalty provision in the law. Dr. Laiben asked about reports from insurance companies and self-insured medical providers. Randy McConnell explained that, with regard to self-insured medical providers, the law requires them to report but provides no penalty for failure to do so. In fact, the Department of Insurance cannot even identify which providers are self-insured.

After several edits, the Commission agreed to the redrafted version of this recommendation. MDI staff has the edits agreed to.

There were no further comments on this issue.

Dr. Laiben asked the Commissioners to consider two items that do not appear in the draft anywhere. He noted they might need to be part of #6. They are: **technology's roll in improving patient safety, and the impact of staff shortages on patient safety.**

With regard to information technology, the Commission agreed something should be said. Dr. Morris reminded the Commission of the testimony regarding the expense and pitfalls of prematurely adopting computerized medical records or physician order entry systems. Nancy Kimmel suggested that each health care organization should evaluate their own technology needs, and the "Center" should serve as a resource for technology expertise. **The Commission agreed to work this issue into both #6 and #1,** to reflect the feeling that both health care providers and the "Center" have a roll to play in adopting technological advancements in patient safety.

With regard to the issue of the nursing shortage, it was noted that a separate Commission is working on this issue. However, the Commission agreed a general statement should be included in the Patient Safety Commission report. Sue Kendig noted that the nursing industry has become very sensitized to the use of staff-to-patient ratios. Dr. Utley suggested that the process of conducting root cause analysis might be sufficient to bring out any problems associated with improper staffing levels. The Commission acknowledged this, but still felt something should be said. Sue Kendig suggested using the concept of access to healthcare professionals generally rather than staffing specifically. **Dr. Morris suggested lifting language from the report an Illinois commission made to the former governor of Illinois. The Commission agreed to use this language as a sub-point under recommendation #6.**

There were no additional comments on these items. Dr. Laiben asked to move on.

Recommendation #7: Patient involvement with the goal of improving safety within healthcare organizations and improving communication between patients and healthcare providers should be enhanced. (Sub-points a through e noted below where individually discussed.)

Kathryn Nelson noted that this recommendation is not one the Commissioners have seen before and asked all Commissioners to please read it carefully.

Nancy Kimmel stated that everyone she showed the draft to enthusiastically supported #7.

Dr. Laiben noted that the sub-points are framed in terms of the "Center" or the Department of Health and Senior Services doing something. He suggested the language should emphasize what the patient can do. Bea Roam suggested that the patient safety officer should accept reports from patients. This would be in addition to having access to ombudsmen. If the entity is too small to support this, the patient should be able to report directly to the "Center". Kathryn Nelson stated that she does not interact directly in most cases with the patient. However, patients can enter a report into her hospital's safety reporting system. **The Commission agreed this should be part of the recommendation.**

Dr. Utley suggested that education on the nature and potential outcomes of treatment, such as the program offered by Graphic Surgery, should be specifically recommended.

Randy McConnell stated he didn't understand #7e ("The Department of Health and Senior Services must continue active responsiveness to consumer complaints about quality of care within Missouri's healthcare organizations.") Kathryn Nelson explained that the intent was to show that the "Center" should not replace the role of the Departments in taking consumer complaints. Nancy Kimmel felt that the Department of Health and Senior Services should not be named by itself. All Departments that take complaints should be included.

There were no further comments on this item. Dr. Laiben asked to move on.

Recommendation # 8: State contracts for payment of healthcare services should be linked to a healthcare organizations' and a healthcare professionals' participation in reporting and other patient safety activities. The state as a purchaser of healthcare should revise contracts for performance expectations for safety/error reduction programs.

This was discussed earlier and was determined that the MDI staff would find a place for this.

Recommendation #9: Malpractice carriers licensed and actively selling malpractice insurance in the state of Missouri should be encouraged to offer a 10% annual premium discount for attending crew resource management or other safety prevention seminars.

Dr. Laiben was concerned about the specific amount of discount being stated. Some providers may be able to negotiate a better discount for themselves. Each professional should be able to work with the insurers to get the best deal possible instead of trying to dictate a set discount.

Kathryn Nelson noted that Tennessee's medical malpractice joint underwriting association offers a 10% discount for the "crew resource" training, which is from the aviation industry. She acknowledged and agreed that there are many possible ways to use discounts, but that the idea tying discounts to the prevention of errors should not be lost. She recommended that the Commission cite the activities of other states in the report.

Linda Bohrer asked if #8 and #9 could be combined. Scott Lakin noted that they both address ways to incentivize improved patient safety. They are both ways for the state to lead in this area. **The Commission agreed to combine these recommendation into one item addressing various incentives to encourage providers to engage in patient safety activities.**
There were no further comments on this item.

III. CLOSING REMARKS AND DISCUSSION OF FUTURE MEETINGS

The Commission agreed to two additional meetings via conference call. The first will be May 27th from 10 AM to 3 PM. The second will be June 17th from 9 AM to 2 PM. Linda Bohrer will prepare the list of recommendations, with today's revisions, in time to send it to all Commissioners before the May conference call. The complete report will be prepared and sent to all Commissioners before the June conference call. **In both cases, Commissioners are encouraged to write their comments in an email and send to all other Commissioners.**

Dr. Laiben noted that, for the Glossary, an attempt will be made to use national definitions wherever possible. MDI staff needs to know if any terms have been left out that should be included, or if any terms currently in the Glossary should be deleted. **If Commissioners have any revisions to definitions, please send those to Linda Bohrer.**

Dr. Laiben asked all Commissioners to read the documents to be sent, so that time spent on the conference calls can be used to its greatest advantage. In addition, he asked all Commissioners to be flexible with the body of the report – the background information. Commissioners should understand that it will not be possible to let 20 or so people closely edit this portion of the report. Staff will see to it that all information is factual.

The meeting was adjourned at 4:30 PM.